Form PBM (09/2016)

Check appropriate box for license requested:

- ☐ Resident License
- ☐ Non-Resident License

Identify Home State: _____

Identify Home State License #: (if applicable) _____

For Office Use Only

Amt. Rec'd _____

Date Rec'd _____

Tracking No. _____

Cashier: _____

COMMONWEALTH OF KENTUCKY
DEPARTMENT OF INSURANCE
P. O. Box 517
Frankfort, Kentucky 40602-0517
email: DOI.AgentLicensingMail@ky.gov
http://insurance.ky.gov
Ph. 502-564-6004 Fax 502-564-6030
(PLEASE PRINT OR TYPE)

PHARMACY BENEFIT MANAGER LICENSE APPLICATION

☐ **New License Application** ☐ **Renewal Application**

Section 1 – Demographic Information

Entity Name	Incorporation/Formation Date (MM/DD/YY)	FEIN
If assigned, National Producer Number (NPN)	State of Domicile	UR Registration #:

List any other assumed, fictitious, alias or trade names under which you are doing business or intend to do business.

Address of Home Office	City	State	ZIP Code
Business Address (Physical Street)	City	State	ZIP Code

Phone Number (include extension) ( ) -	Fax Number ( ) -	Business E-Mail Address	Business Website Address

Mailing Address	P.O. Box	City	State	ZIP Code

Listing of entities/individuals for which the PBM provides services (within Kentucky only):

Applicant Background Information

Attach a full explanation and/or the requested information for questions below as an attachment to this application. Failure to provide the required attachments or any omissions may result in the denial of this application.

Has the applicant been refused a registration, license or certification to act as (or provide the services of) a Pharmacy Benefit Manager, Pharmacy Benefit Management Plan, Pharmacy Benefits Processor, Third Party Administrator, Third Party Provider, etc., or has any registration, license or certification to act as such been denied, suspended, revoked or non-renewed for any reason by any state or federal entity? *(Attach specific details separately.)*	☐ YES ☐ NO
Has the applicant ever been found liable in any lawsuit or arbitration proceeding involving allegations of fraud, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? *(Attach specific details separately.)*	☐ YES ☐ NO
Has the applicant had a business relationship with an insurance company terminated for any alleged fraudulent, illegal or dishonest activities in connection with the administration of pharmacy benefit management services? *(Attach specific details separately.)*	☐ YES ☐ NO
Has the applicant, parent company or any company or organization controlling the operation of the Pharmacy Benefit Manager experienced any data security breaches or HIPAA security breaches? *(If YES please attach all pertinent information concerning any data security breach. Any future data security breach must be reported immediately to the Kentucky Department of Insurance.)*	☐ YES ☐ NO
Does the applicant own, operate or affiliate with any pharmacy located outside of Kentucky that ships, mails or delivers in any manner, controlled substances, prescription or legend drugs or devices into Kentucky?	☐ YES ☐ NO

Section 2 – Service of Process Agent for Pharmacy Benefit Manager

Name _____

Address _____ City _____ State _____ ZIP Code _____

Phone Number ( ) _____ E-Mail Address _____

Section 3 –Licensed Administrator Acting on Behalf of the Pharmacy Benefit Manager

List primary contact person(s) responsible for regulatory compliance on behalf of the Pharmacy Benefit Manager:

Name_____ Official Title_____

Phone: _____ Email: _____ NPN or DOI ID#: _____

Name_____ Official Title_____

Phone: _____ Email: _____ NPN or DOI ID#: _____

Name_____ Official Title_____

Phone: _____ Email: _____ NPN or DOI ID#: _____

Section 4 – Individuals Responsible for the Compliance and Conduct of Affairs for Pharmacy Benefit Manager

List all individuals responsible for the compliance/conduct of affairs, <u>including</u> members of the board of directors, board of trustees, executive committee, other governing board or committee, the principal officers in the case of a corporation, the partners or members in the case of a partnership or association, and any other person who exercises control or influence over the affairs of the Pharmacy Benefit Manager.

1. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
2. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
3. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
4. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
5. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
6. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
7. Name_____ Official Title_____
   Address_____ Professional Qualifications_____
8. Name_____ Official Title_____
   Address_____ Professional Qualifications_____

(Attach additional sheets if necessary)

Section 5 - Administration and Operation: The following documentation must be submitted with this application.

1. Attach a detailed description of the *MAC Pricing Dispute Appeal Process* to be used by contracted pharmacies, pharmacy services and administration organizations or group purchasing organization, including the appeals policy and procedure, pursuant to KRS 304.17A-162 (1) (b).
2. Attach the policy and procedure used for making price updates warranted as a result of an appeal granted under KRS 304.17A-162, including PBM's means of providing notification to all other contracted pharmacies in the network.
3. Identify the national drug pricing compendia or sources used to obtain drug price data for every drug for which the PBM establishes a maximum allowable cost to determine the product reimbursement, pursuant to KRS 304.17A-162(3).
4. Identify the location of PBM's comprehensive list of every drug subject to MAC pricing, per KRS 304.17A-162(4).
5. Attach the policy and procedure to be used for updating MAC pricing every seven days and the PBM's ability to provide notification to all contracted pharmacies (KRS 304.17A-162 (6) and (7)).
6. Attach the policy and procedure that ensures that every drug subject to MAC pricing meets requirements set forth in KRS 304.17A-162(8) through KRS 304.17A-162(13).
7. Attach the policy and procedure relating to the resolution of MAC pricing complaints which are filed with the Kentucky Department of Insurance, including timeframes and sample appeal response letter.
8. Attach the *Exceptions Policy* that allows an enrollee, designee, or prescribing provider to gain access to clinically appropriate drugs not otherwise covered by the plan, and includes a standard and expedited procedure. (45 CFR 156.122).
9. Provide the policy that explains the process that gives the ability to access prescriptions from an in-network retail, unless special handling or another reason proves that the prescription cannot be provided by a retail pharmacy. (45 CFR 156.122).
10. Attach the policy explaining any Pharmacy and Therapeutics committee membership standards and duties, including how often the committee meets, structure, and the decision-making process.
11. Attach proof of financial responsibility in the amount of one million dollars ($1,000,000).
12. Attach proof of registration with the Kentucky Secretary of State's office in order to do business in Kentucky.
13. Attach $1,000 non-refundable fee (KRS 304.9-200(4)), made payable to the Kentucky State Treasurer.

Section 6 - Applicant's Certification and Attestation

On behalf of the Pharmacy Benefit Manager, applicant hereby certifies, under penalty of perjury, that:

1. All of the information submitted in this application and attachments is true and complete and I am aware that submitting false information or omitting pertinent or material information in connection with this application is grounds for license or registration revocation and may subject me and the applicant to civil or criminal penalties.
2. The applicant grants permission to the Kentucky Department of Insurance or other appropriate party in the Commonwealth of Kentucky to verify any information supplied with any federal, state or local government agency, current or former employer or insurance company.
3. I authorize the Kentucky Department of Insurance to give any information they may have concerning me, as permitted by law, to any federal, state or municipal agency, or any other organization and I release the Kentucky Department of Insurance, and any person acting on their behalf, from any and all liability of whatever nature by reason of furnishing such information.
4. I acknowledge that I understand and comply with the insurance laws and regulations of Kentucky.
5. I hereby certify that I will furnish any additional information upon request.

Must be signed by an officer, director, or partner of the entity, or member or manager of a limited liability company who has authority to act on behalf of the entity:

_____ _____
Signature **Date**

_____ _____
Typed or Printed Name **Title**

_____
Address line 1

_____
Address line 2

_____
City **State** **ZIP**